Evidence for change of year of birth of deceased is shown on FILM No. 100 FEB 5 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (43)

CERTIFICATE OF DEATH

00488

Reg. Dist. No. 100

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A5

1. PLACE OF DEATH:

County: Charles

City or town: Newburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: —

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Charles

City or town: Newburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. —

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Edith Matthews Blunt

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 31, 1865 1875

8. AGE:

Years	Months	Days	If less than one day
70	2	25	..... hrs. ..... min.

9. Birthplace: Charles Co., Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own home

FATHER

12. Name: William Bruce Matthews

13. Birthplace: Chas. Co. Md.

MOTHER

14. Maiden name: Ann Freeman Dorsett

15. Birthplace: Chas. Co. Md.

16. Informant: Mrs. A. G. Hungerford

Address: Newburg Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-27-46 (month) (day) (year)

Cemetery or crematory: Mt. Rest

Location: La Plata Md.

18. Funeral director: Hurst & Ryan

Address: Waldorf Md

19. 1-26 (Date rec'd by registrar) 1946 Julia H. Posey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: JAN. 25, 1946, at 11 00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 6, 1945, to JAN. 25, 1946

and that I last saw h.. alive on JAN. 25, 1946

Immediate cause of death: Carcinoma of head of Pancreas — DURATION: Symptomatic 2 mos.

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: James L. MacKavanagh, M.D. (M. D. or other)

Address: La Plata, Md. Date signed 1-26-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

CERTIFICATE OF DEATH

0648

Reg. Dist. No. 103

[redacted] 1946

1. PLACE OF DEATH:
County: Chas Co
City or town: Faulkner md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Charles
City or town: Faulkner md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Mamie E. Jemorick

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	C	Wid

6.(b) Name of husband or wife: Jno

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 30 - 1895?

8. AGE: Years	Months	Days	If less than one day
51			..... hrs. ..... min.

9. Birthplace: Hicomico md (Town, county, and state)

10. Usual occupation: House Wife

11. Industry or business

FATHER
12. Name: Jeff Knott
13. Birthplace: Chas Co Md

MOTHER
14. Maiden name: Mary Barbour
15. Birthplace: Chas Co md

16. Informant: Blanche Brown (Daughter)
Address: Spring Hill md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-26-46 (mouth) (day) (year)
Cemetery or crematory: St Marys
Location: New Patt md

18. Funeral director: Hunt & Ryon
Address: Waldorf md

19. Jan. 25 1946 (Date rec'd by registrar) Mary E. Burch Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 23 1946, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from JANUARY 1st 1945, to JAN 23 1946
and that I last saw h. ALIVE on JAN 23-46 1946

Immediate cause of death	DURATION
CHRONIC MYOCARDITIS	1 yr.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Ernest Spence Jr. M.D.
M. D. or other
Address: Bel Alton Md Date signed 1-23-46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131-a

CERTIFICATE OF DEATH

00482 / 05

Reg. Dist. No. ____

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Charles
City or town: Waldorf, Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Charles
City or town: Waldorf (Rural)
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: William Purcell Gardiner

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of ~~husband~~ or wife: Agnes Gardiner
6.(c) If alive, give age: 45 years

7. Birth date of deceased (mo., day, yr.): May 15, 1891

8. AGE: Years	Months	Days	If less than one day
54	8	9	____ hrs. ____ min.

9. Birthplace: Waldorf, Md. (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business

MOTHER FATHER
12. Name: Algernon B. Gardiner
13. Birthplace: Waldorf, Md.

MOTHER
14. Maiden name: Mary A. Burch
15. Birthplace: Bryantown, Md.

16. Informant: Elbert Gardiner
Address: Waldorf, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/28/46 (month) (day) (year)
Cemetery or crematory: St. Peters
Location: Waldorf, Md.

18. Funeral director: Hyatt & Ryon
Address: Waldorf, Md.

19. Jan 28 19 46 W. L. Hyatt Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 24 1946, at 11 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 19 46 to 1/24 19 46 and that I last saw h...m alive on 1/24/46 19 ____

Immediate cause of death	DURATION
(a) Cardiac Decompensation	
Due to: Cardio-Vas-Renal Disease	4 years
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Chas. D. Worden, M.D.
M.D. or other
Address: Waldorf, Md. Date signed 1/28/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01483

Reg. Dist. No. 101

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Charles

City or town: Pomonkey

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Home of Mrs. Mollie Clark

Stay in hospital or instn. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Charles

City or town: Pomonkey Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(c) IF VETERAN, NAME WAR

3. (a) FULL NAME Julia Dean

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 9, 1946

8. AGE:

Years	Months	Days	If less than one day
			17 hrs. min.

9. Birthplace: Pomonkey, Md. (Town, county, and state)

10. Usual occupation: Infant

11. Industry or business

FATHER 12. Name: Paul Dean

13. Birthplace: Pomonkey, Md.

MOTHER 14. Maiden name: Dot Hebron

15. Birthplace: Pisgah, Md.

16. Informant: Dot Dean

Address: Pisgah Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/11/46 (month) (day) (year)

Cemetery or crematory: Pleasant Grove Baptist Church

Location: Marbury, Md.

18. Funeral director: Paul H. Posey

Address: Bryantsville Road Md

19. June 11 1946 (Date rec'd by registrar) Mary Sutherland, Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 10, 1946, at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from ---, 19--, to 1/10, 1946, and that I last saw h--- alive on ---, 19---.

Immediate cause of death: Atelectasis — DURATION: 1 day

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank G. Lyon M.D. or other

Address Indian Head Md Date signed 1/11/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

06484

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

Reg. Dist. No. 106

1. PLACE OF DEATH:
County: County
City or town: Pomfret
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Charles
City or town: Pomfret
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Fanny Green
3.(b) Social Security Number:

4. Sex: F
5. Color or race: C
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife: James Green
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): Dec. 31 1868
8. AGE: Years 77 Months 0 Days 22 If less than one day ... hrs. ... min.
9. Birthplace: Newport Charles Co. Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:

FATHER
12. Name: — Ford
13. Birthplace: Charles Co. Md.

MOTHER
14. Maiden name: — Campbell
15. Birthplace: Charles Co. Md.

16. Informant: Florence E. Green
Address: Pomonkey Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 26 1946 (month) (day) (year)
Cemetery or crematory: St. Thomas
Location: Bel Alton Md.
18. Funeral director: [illegible]
Address: Waldorf Md
19. 1-25-46 (Date rec'd by registrar) Stanly Penny Mason Spgs Md Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 22 1946 at 10:05 a.m.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 20 1946, to ... 19..
and that I last saw h... alive on ... 19..

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations ... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: Geo. C. Bicknell M.D. (M. D. or other)
Address: Marbury Md. Date signed: Jan 22 46

1-25-46 Mr. Ransome D.S.R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (69)

00485

CERTIFICATE OF DEATH

Reg. Diat. No. 101

1. PLACE OF DEATH:
County: Charles
City or town: Ironsides
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Charles
City or town: Ironsides
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Hattie A. Henderson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: William Henderson
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 12, 1881

8. AGE:

Years	Months	Days	If less than one day
64	10	25	hrs. min.

9. Birthplace: Ironsides Charles Co. Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER 12. Name: James Ryson
13. Birthplace: Charles Co. Md.
MOTHER 14. Maiden name: Unknown
15. Birthplace: "
16. Informant: Wm Henderson
Address: Ironsides Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 9 1946 (month) (day) (year)
Cemetery or crematory: Burland
Location: Ironsides Md
18. Funeral director: Hunt & Ryson
Address: Waldorf Md
19. June 7 1946 (Date rec'd by registrar) Mary Smallwood Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 7 1946, at 6:30 A. M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from February 1945 to June 7 1946
and that I last saw her alive on Jan 2 1946

Immediate cause of death	DURATION
Pellagra	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Geo. A. Bickwell M.D.
M. D. or other
Address: Marlboro Md. Date signed: Jan 7 46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

STATE OF MARYLAND—CERTIFICATE OF DEATH

00486

1. PLACE OF DEATH (46)

County Charles Registration Dist. No. 104

Village or City Newburg No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Ruth V. Hill If U. S. Veteran, specify WAR

(a) Residence: No. St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
F	W	married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Arthur Hill

6. DATE OF BIRTH (month, day, and year) April 25 - 1903

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43	8	11	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Housewife

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Newburg (State or country)

FATHER

13. NAME Thomas Meredith

14. BIRTHPLACE (city or town) Newburg (State or country)

MOTHER

15. MAIDEN NAME Rebecca Rhodes

16. BIRTHPLACE (city or town) Newburg (State or country)

17. INFORMANT Wm. Smallwood (Address) Newburg

18. BURIAL, CREMATION, OR REMOVAL Place Shiloh Data 1 - 8 -, 1946

19. UNDERTAKER Hewitt & Myers (Address) Waldorf

20. FILED 1/7, 1946 - William Trera Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH 1 (Month) 0 - (Day), 1946 (Year)

22. I HEREBY CERTIFY, That I attandad daceasad from Mar. 31, 1945 to 1 - 6 -, 1946

I last saw her alive on 1 - 3 -, 1946 death is said to hava occurrad on the date stated abova, at 2 P. m.

The **PRINCIPAL CAUSE OF DEATH** and related causes of importance ware as follows:

	Date of onset
Cancer of Stomach	

Other **Contributory Causes** of importance:

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If daath was due to externa1 causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of Injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, In HOME, or In PUBLIC PLACE.

Manner of injury

Neture of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, spacify

(Signed) J. K. Hazelan M. D.

(Address) Waldorf

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

M

MARGIN RESERVED FOR BINDING

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel,** etc. For a person who had no occupation whatever write **none.**

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver,** etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill,** etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer,** etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist,** etc. Distinguish carefully between **retail merchants** and **wholesale merchants.** A person who sells goods should be called a **salesman** and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I		Example II	
The principal cause of death and related causes of importance were as follows:	Date of onset	The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*	*Attack of epilepsy*	*1 week ago*
Chronic interstitial nephritis	*1921*	*Run over by street car*	*1 week ago*
Cerebral hemorrhage	*July 5, 1927*	*Peritonitis*	*3 days ago*
Other contributory causes of importance:		Other contributory causes of importance:	
Gallstones	*May 1, 1923*	*Gastroenteritis*	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

001487

★ Reg. Dist. No. 106

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Charles

City or town: Pomonkey

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or Institution: J

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 2 months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Charles.

City or town: Pomonkey Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Hilda Regina Jordan

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 4, 1945

8. AGE: Years | Months: 1 | Days: 29 | If less than one day: hrs. min.

9. Birthplace: Pomonkey Md (Town, county, and state)

10. Usual occupation: Infant

11. Industry or business

FATHER 12. Name: Godfrey Oswald Jordan

13. Birthplace: Pomonkey, Md.

MOTHER 14. Maiden name: Marie Sylvester Davis

15. Birthplace: Washington D C

16. Informant: Hattie Fagan

Address: Pomonkey Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 5, 1945 (month) (day) (year)

Cemetery or crematory: Metropolitan ME Cemetery

Location: Pomonkey Md.

18. Funeral director: Penny & Cofer

Address: Mason Springs Md

19. 1-3-1946 (Date rec'd by regiatrar) M. E. Ransome O. L. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 2 1946, at 4 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 29 1945 to Jan 3 1945, and that I last saw h alive on Jan 3 1945.

Immediate cause of death: Bronchopneumonia, bilat. — DURATION: 5 days

Due to: Virus Infection

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Dt operations

Dt autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: Frank Jones M D (M. D. or other)

Address: Indian Head, Md. Date signed 1/3/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06489

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH:
County Charles
City or Town PORT TOBACCO
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? LIFE
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County CHAS
City or town PORT TOBACCO
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME JOSEPHINE MUSCHETT

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	COL	SINGLE

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APR 7-26

8. AGE: Years	Months	Days	If less than one day
19	9	9	hrs. min.

9. Birthplace NR. PORT TOBACCO (Town, county, and state)
10. Usual occupation LABORER
11. Industry or business USN POWDER FACTORY

FATHER
12. Name GEORGE MUSCHETT SR.
13. Birthplace POMFRET MD.

MOTHER
14. Maiden name ELIZABETH SHORTER
15. Birthplace POMFRET MD

16. Informant GEORGE MUSCHETT
Address PORT TOBACCO RD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-18-46 (month) (day) (year)
Cemetery or crematory St Joseph
Location Pomfret MD
18. Funeral director Hunt & Ryon
Address Waldorf MD

19. F 18 1946 (Date rec'd by registrar) Julia H. Posey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-15 19 46, at 1245 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-10 19 45, to 1-15 19 45
and that I last saw h alive on 19

Immediate cause of death	DURATION
LOBAR PNEUMONIA	5 DAYS
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Emmett S Norman M.D.
M. D. or other
Address BEL ALTON MD. Date signed 1-16-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

00490

Reg. Diat. No. 101

1. PLACE OF DEATH:

County Charles

City or town Pomonkey

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Nancy A. Myers.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	C	Widowed.

6.(b) Name of husband or wife Fred W. Myers

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1859

8. AGE: Years 87 | Months | Days | If less than one day hrs. min.

9. Birthplace Charles Co. Maryland (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Alexander

13. Birthplace Charles Co. Md.

MOTHER 14. Maiden name Cecelia Key

15. Birthplace Charles Co. Md

16. Informant Fred D. Myers.

Address Croom Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 24 1946 (month) (day) (year)

Cemetery or crematory Methodist

Location Pomonkey, Md.

18. Funeral director J. B. Johnson

Address Annapolis Md.

19. 1/24 1946 Mary Sweetenham Local Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 24 1946, at 1.0 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1943, to 19..., and that I last saw h...er alive on 19 46

Immediate cause of death	DURATION
Senile debility.	
Anemia	
Due to Arteriosclerosis	
Due to	
Other conditions Amputation of L Leg in 1948. Anemia	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE George C. Bicknell M.D. M. D., or other

Address Pomonkey Md. Date signed Jan 25 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

00491

Reg. Dist. No. 83

1. PLACE OF DEATH:
County: Charles
City or town: White Plains, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Chas
City or town: Bidingsley Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: George Pinkney Nevett

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	White	Married

6.(b) Name of ~~husband~~ or wife: Mary Nevett
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 16, 1883

8. AGE: Years	Months	Days	If less than one day
62	3		..... hrs. ..... min.

9. Birthplace: Chas. Co. Md.
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business

FATHER
12. Name: Robert Nevett
13. Birthplace: Chas. Co. Md.

MOTHER
14. Maiden name: Jane Greer
15. Birthplace: ~~Chas~~ Pr. Geo. Co.

16. Informant: Mrs Mary Lillian Wenk
Address: White Plains, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-19-46 (month) (day) (year)
Cemetery or crematory: Mt Rest
Location: La Plata Md
18. Funeral director: Hurtt & Ryon
Address: Waldorf Md
19. 1-19 (Date rec'd by registrar) 19 46 M. L. Tubbs Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 16, 1946 at 1:20 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased ~~from~~ on Jan. 16, 1946 to ..... 19..... and that I ~~last saw him alive~~ on Jan. 16, 1946

Immediate cause of death	DURATION
Cerebral hemorrhage	30'
Due to: Generalized arteriosclerosis	?
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, ~~or homicide~~: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Jas. L. Mackenzie, M.D., Dr. of Med. Exam. M.D. or other
Address: La Plata, Md Date signed 1-18-46

M

MARGIN RESERVED FOR BINDING

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95-C)

CERTIFICATE OF DEATH

00492

Reg. Dist. No. 101

1. PLACE OF DEATH:

County: Charles

City or town: Hill Top

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Charles

City or town: Hill Top

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Carrie Elizabeth Perry

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: 1st Mrs. Franklin 2nd Edward Perry

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): June 30, 1872

8. AGE: Years 73 | Months 6 | Days 7 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Charles Co. Md (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Rufus Davis

FATHER — 13. Birthplace: Charles Co. Md.

MOTHER — 14. Maiden name: Elizabeth Barker

MOTHER — 15. Birthplace: Charles Co Md

16. Informant: Mrs Kate Davis

Address: Hill Top Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 10 1946 (month) (day) (year)

Cemetery or crematory: St. Thomas,

Location: Chapel Point Md.

18. Funeral director: Public & Repos

Address: Waldorf R.D. Md

19. Jan. 10 1946 (Date rec'd by registrar) Mary E. Bowie Registrar Dept.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 6 1946, at 8 30/60 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sick 1945, to Jan 1945

and that I last saw her alive on Dec 29 1945

Immediate cause of death: Chr Cardiac Disease — DURATION

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ..... Injured at work?

23. SIGNATURE: Geo. C. Bicknell M.D. (M. D. or other)

Address: Marbury Md Date signed: Jan 8 1946

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (19-a)

00493

CERTIFICATE OF DEATH

Reg. Dist. No. 101

1. PLACE OF DEATH:

County: Charles

City or town: Issueides

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Charles

City or town: Issueides

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: John Eugene Risko

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 23 1945

8. AGE:

Years	Months	Days	If less than one day
	1	12	..... hrs. ..... min.

9. Birthplace: La Plata Charles Co. Md.

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER — 12. Name: Steve Risko

FATHER — 13. Birthplace: Pennsylvania

MOTHER — 14. Maiden name: Sophie Rydzska

MOTHER — 15. Birthplace: Rutland Vermont.

16. Informant: Steve Risko

Address: Issueides, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 8 1946 (month) (day) (year)

Cemetery or crematory: Hill Top Catholic

Location: Hill Top, Md.

18. Funeral director: John R. Welch

Address: Issueides Md.

19. Jan. 7 1946 (Date rec'd by registrar) Mary Swetland Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 5 19 46, at 11 45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 23 1945, to Jan 5 1946 and that I last saw h... alive on Jan 5 1946

Immediate cause of death	DURATION
Ac Gastro Enteritis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: Geo. C. Bickwell M.D.

M. D. or other

Address: Marbury Md Date signed: Jan. 7 46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00494 105

Reg. Dist. No.

1. PLACE OF DEATH:
County: Charles
City or town: Bryantown Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Two months
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: County:
City or town: Washington D C
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Addie May Scott

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Frank L. Scott
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 2 1865

8. AGE:

Years	Months	Days	If less than one day
80	7	29	hrs. min.

6. Birthplace: Washington D C
(Town, county, and state)
10. Usual occupation: Clerk War Dept.
11. Industry or business: —
FATHER 12. Name: George W Cheseldine
13. Birthplace: St Marys Co Md.
MOTHER 14. Maiden name: Rosa L. Compton
15. Birthplace: Va.
16. Informant: Mrs Evelyn L. Scott
Address: Bryantown Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 4 1946 (month) (day) (year)
Cemetery or crematory: Arlington
Location: Va
16. Funeral director: J. Wm Lee Sons Co
Address: 3064 St NE Washington DC
19. 1-31-46 (Date rec'd by registrar) M. L. Thomas Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 31st 1946, at 7:30 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 24 1946 to Jan 24 1946 and that I last saw h.. alive on Jan 24th 1946

	DURATION
Immediate cause of death: Cerebral Thrombosis	Hours
Due to:	
Due to:	
Other conditions: Hyp. Heart Disease	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

32. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

21. SIGNATURE: Leon J Cochran M. D. or other
Address: Charlotte Hall Date signed: Jan 31 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83)

00495

CERTIFICATE OF DEATH

Reg. Dist. No. 102

1. PLACE OF DEATH:

County Charles

City or town Maryland Point

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Charles

City or town Mdu Pt.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Rachel Washington

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	C	married

6.(b) Name of husband or wife John Henry Washington

6.(c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years 66 | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace Montgomery Charles Co. Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Anthony Savoy

13. Birthplace Charles Co. Md

MOTHER 14. Maiden name Winnie Moore

15. Birthplace Charles Co. Md.

16. Informant Edgar Haywood

Address Grayton Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 25 46 (month) (day) (year)

Cemetery or crematory Oak Grove

Location Waldorf Md

18. Funeral director S Bowling Penny

Address Mason Springs Md

19. Jan 25th 1946 (Date rec'd by registrar) C R Thompson Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 21 1946 at 9 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 21 1946 to ... 19...

and that I last saw h... as... alive on Jan 21 1946

Immediate cause of death	DURATION
Cerebral Apoplexy	
Due to Arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Geo. A. Bicknell M.D.
M. D. or other

Address Waldorf Md Date signed Jan 25 46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (96)

00496

CERTIFICATE OF DEATH

Reg. Diat. No. 100

1. PLACE OF DEATH:
County: Charles
City or town: Newburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: County:
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No.:
(If rnral, give LOCATION)
2.(a) If veteran, name wer:

3. (a) FULL NAME Julia Irene Wills

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	Col	Married

6.(b) Name of husband or wife: Mitchell Wills

6.(c) If alive, give age: 48 years

7. Birth date of deceased (mo., day, yr.): July 1, 1899

8. AGE:

Years	Months	Days	If less than one day
46	7	28	hrs. min.

9. Birthplace: Chas. Co. Md.
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business

FATHER
12. Name: Joseph Beom
13. Birthplace: Chas. Co. Md.

MOTHER
14. Maiden name: Rosetta Jackson
15. Birthplace: Chs. Co. Md.

16. Informant: Laura Gordon
Address: Newburg Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/2/46 (month) (day) (year)
Cemetery or crematory: Shiloh M.E.
Location: Mt. Victoria Md

18. Funeral director: Smith & Penn
Address: Waldorf, Md.

19. 2-2 (Date rec'd by registrar) 1946 Julia H. Penn Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 29 19 46, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death: Ruptured Aortic Aneurysm — DURATION: 1-24-46
Due to:
Due to: Arterio-Sclerosis
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D.
M. D. or other
Address: La Plata Md. Date signed 2-2-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15